

Facility Name & ID Number PARKVIEW TERRACE

0045294 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>24</u>	Skilled (SNF)	<u>24</u>	<u>8,760</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>96</u>	Intermediate (ICF)	<u>96</u>	<u>35,040</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>2,024</u>	<u>2,024</u>	8
9	SNF/PED					9
10	ICF	<u>18,396</u>	<u>7,355</u>		<u>25,751</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,396</u>	<u>7,355</u>	<u>2,024</u>	<u>27,775</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.41%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 02/01/01

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 02/01/01 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 22 and days of care provided 2,024

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **PARKVIEW TERRACE** # **0045294** Report Period Beginning: **01/01/2003** Ending: **12/31/2003**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	121,695	7,828	8,141	137,664		137,664		137,664			1
2	Food Purchase		111,451		111,451		111,451	(1,076)	110,375			2
3	Housekeeping	76,734	9,238		85,972		85,972		85,972			3
4	Laundry	30,544	8,474		39,018		39,018		39,018			4
5	Heat and Other Utilities			90,021	90,021		90,021	1,868	91,889			5
6	Maintenance	42,566	19,462	4,161	66,189		66,189	10,055	76,244			6
7	Other (specify):*			5,734	5,734		5,734	98	5,832			7
8	TOTAL General Services	271,539	156,453	108,057	536,049		536,049	10,945	546,994			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	874,562	47,036	10,215	931,813		931,813	13,636	945,449			10
10a	Therapy	24,242		9,432	33,674		33,674		33,674			10a
11	Activities	41,122	430	385	41,937		41,937	(385)	41,552			11
12	Social Services	41,347			41,347		41,347		41,347			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	981,273	47,466	32,032	1,060,771		1,060,771	13,251	1,074,022			16
	C. General Administration											
17	Administrative	115,556			115,556		115,556	7,929	123,485			17
18	Directors Fees											18
19	Professional Services			45,364	45,364		45,364	(10,904)	34,460			19
20	Dues, Fees, Subscriptions & Promotions			32,978	32,978		32,978	(2,001)	30,977			20
21	Clerical & General Office Expenses	98,257	7,895	32,333	138,485		138,485	17,959	156,444			21
22	Employee Benefits & Payroll Taxes			240,501	240,501		240,501		240,501			22
23	Inservice Training & Education			1,640	1,640		1,640	344	1,984			23
24	Travel and Seminar			18,027	18,027		18,027	9,059	27,086			24
25	Other Admin. Staff Transportation			22,269	22,269		22,269	5,142	27,411			25
26	Insurance-Prop.Liab.Malpractice			84,480	84,480		84,480	623	85,103			26
27	Other (specify):*			3,776	3,776		3,776	9,983	13,759			27
28	TOTAL General Administration	213,813	7,895	481,368	703,076		703,076	38,134	741,210			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,466,625	211,814	621,457	2,299,896		2,299,896	62,330	2,362,226			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	8,141
	REPAIRS & MAINTENANCE		0
			0
			8,141
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		32,093
	ELECTRICITY		25,512
	WATER		31,610
	CABLE TV - LOBBY		806
			0
			90,021
6	MAINTENANCE		
	GROUNDS MAINTENANCE		2,632
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE TRAVEL		0
	EQUIPMENT MAINTENANCE & REPAIR		0
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		0
	FIRE SERVICE		1,529
			0
			0
			0
			4,161
7	OTHER		
	SCAVENGER		3,762
	SECURITY SERVICE		1,972
			5,734
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	12,000
			12,000

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	
	LABORATORY & XRAY EXPENSE		3,995
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	1,385
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	450
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	4,385
			0
			0
			10,215
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,703
	OCCUPATIONAL THERAPY CONSULTANT	XVIII B 41-2	3,729
	RESPIRATORY THERAPY CONSULTANT	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			9,432
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	385
			0
			385
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTANT	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			0
			0
			0
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	0	0
17	ADMINISTRATIVE		
	MANAGEMENT FEES XIX B	0	0
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING XIX C	13,327	
	ADMINISTRATIVE CONSULTANTS XIX C	7,528	
	PROFESSIONAL FEES XIX C	19,104	
	BOOKKEEPING/ADMINIST. SERVICE	5,405	45,364
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	2,160	
	EMPLOYEE WANT ADS XIX F	19,457	
	CONTRIBUTIONS VI 20 XIX F	320	
	DUES & SUBSCRIPTIONS XIX F	7,025	
	LICENSES & PERMITS XIX F	2,828	
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0	
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,188	32,978
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	7,463	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	0	
	PENALTIES / OVERDRAFT CHARGES VI 18	1,257	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	22,780	
	MESSENGER SERVICE	833	
		0	32,333

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES XIX D	116,021	
	UNEMPLOYMENT COMPENSATION XIX D	11,963	
	WORKERS COMPENSATION INSURANCE XIX D	73,860	
	HOSPITALIZATION INSURANCE XIX D	28,996	
	EMPLOYEE BENEFITS - OTHER XIX D	9,661	
	EMPLOYEE PHYSICAL EXAMS XIX D	0	
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS XIX D	0	
	CHICAGO HEAD TAX XIX D	0	240,501
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	1,640	1,640
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS XIX G	0	
	TRAVEL XIX G	18,027	
		0	
		0	18,027
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	22,269	22,269
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	84,480	84,480
27	OTHER		
	BAD DEBTS VI 24	3,776	
		0	3,776

GRAND TOTAL COLUMN 3 OTHER

621,457

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			2,705	2,705		2,705	(704)	2,001			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,941	32,941		32,941	118	33,059			32
33	Real Estate Taxes			78,053	78,053		78,053		78,053			33
34	Rent-Facility & Grounds			279,505	279,505		279,505	6,910	286,415			34
35	Rent-Equipment & Vehicles			30,494	30,494		30,494	7,014	37,508			35
36	Other (specify):*											36
37	TOTAL Ownership			423,698	423,698		423,698	13,338	437,036			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,178	82,432	99,610		99,610		99,610			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		17,178	148,132	165,310		165,310		165,310			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,466,625	228,992	1,193,287	2,888,904		2,888,904	75,668	2,964,572			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,153)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,076)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(1,257)	21		18
19	Entertainment		20		19
20	Contributions	(320)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,776)	27		24
25	Fund Raising, Advertising and Promotional	(2,160)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(37,235)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (46,977)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	122,645		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 122,645		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 75,668		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	MARKETING SALARY	\$ (37,235)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(37,235)		49

Summary A

12/31/2003

[illegible]

Summary B

12/31/2003

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MELVIN SIEGEL	49.00	ARC OF JACKSONVILLE	JACKSONVILLE	MAVIN	SKOKIE, IL	CONSULTING,
SUZANNE KOENIG	51.00	LITCHFIELD TERRACE	LITCHFIELD	ENTERPRISES LTD		BOOKKEEPING
		RIVER VIEW MANOR	LOVES PARK			
		SPRINGFIELD TERRACE	SPRINGFIELD			
		VANDALIA TERRACE	VANDALIA			
		GOLDEN MOMENTS	JACKSONVILLE			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	PSYCH-SOCIAL CONSULTANT	\$ 1,385	MAVIN ENTERPRISES LTD		\$	(1,385)	1
2	V	11	ACTIVITY CONSULTANT	385				(385)	2
3	V	19	ADMIN/BK KP. FEES	5,405				(5,405)	3
4	V	19	ADMIN. CONSULT. FEES	7,528				(7,528)	4
5	V								5
6	V	5	ELECTRICITY/GAS				1,868	1,868	6
7	V	6	MAINTENANCE				10,055	10,055	7
8	V	7	SCAVENGER				98	98	8
9	V	10	PSYCH-SOCIAL & NURSING CONSULT				15,021	15,021	9
10	V	17	ADMINISTRATIVE SALARIES				7,929	7,929	10
11	V	19	PROFESSIONAL FEES				2,029	2,029	11
12	V	20	ADVERTISING				479	479	12
13	V	21	TOTAL OFFICE				56,451	56,451	13
14	Total			\$ 14,703			\$ 93,930	\$ * 79,227	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	23	SEMINAR	\$	MAVIN ENTERPRISES LTD		\$ 344	\$ 344	15
16	V	24	TRAVEL				9,059	9,059	16
17	V	25	TRANSPORTATION				5,142	5,142	17
18	V	27	EMPLOYEE BENEFITS				13,759	13,759	18
19	V	30	DEPRECIATION (SL)				449	449	19
20	V	32	INTEREST				118	118	20
21	V	34	OFFICE RENT				6,910	6,910	21
22	V	35	EQUIPMENT RENT				7,014	7,014	22
23	V	26	INSURANCE				623	623	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 43,418	\$ * 43,418	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6					SEE ATTACHED						6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PARKVIEW TERRACE# 0045294 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization MAVIN ENTERPRISES, LTD
Street Address 3845 OAKTON
City / State / Zip Code SKOKIE, IL 60076
Phone Number (847) 679-0100
Fax Number (847) 679-0647

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	ELECTRICITY/GAS	PATIENT DAYS	141,473	7	\$ 9,514	\$	27,775	\$ 1,868	1
2	6	MAINTENANCE	PATIENT DAYS	141,473	7	51,216	50,100	27,775	10,055	2
3	7	SCAVENGER	PATIENT DAYS	141,473	7	500		27,775	98	3
4	10	PSYCH-SOCIAL & NURSING	PATIENT DAYS	141,473	7	76,511		27,775	15,021	4
5	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	141,473	7	40,388	40,388	27,775	7,929	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	141,473	7	10,333		27,775	2,029	6
7	20	ADVERTISING	PATIENT DAYS	141,473	7	2,442		27,775	479	7
8	21	TOTAL OFFICE	PATIENT DAYS	141,473	7	287,536	218,675	27,775	56,451	8
9	23	SEMINARS	PATIENT DAYS	141,473	7	1,750		27,775	344	9
10	24	TRAVEL	PATIENT DAYS	141,473	7	46,140		27,775	9,059	10
11	25	TRANSPORTATION	PATIENT DAYS	141,473	7	26,191		27,775	5,142	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	141,473	7	70,083		27,775	13,759	12
13	30	DEPRECIATION (SL)	PATIENT DAYS	141,473	7	2,285		27,775	449	13
14	32	INTEREST	PATIENT DAYS	141,473	7	601		27,775	118	14
15	34	OFFICE RENT	PATIENT DAYS	141,473	7	35,195		27,775	6,910	15
16	35	EQUIPMENT RENT	PATIENT DAYS	141,473	7	35,725		27,775	7,014	16
17	26	INSURANCE	PATIENT DAYS	141,473	7	3,172		27,775	623	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 699,582	\$ 309,163		\$ 137,348	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$				\$	1
2												2
3												3
4												4
5	MGMT CO ALLOCATION										118	5
	Working Capital											
6	LASALLE BANK		X	LINE OF CREDIT	DEMAND	2/01	450,000	433,546		5.1250	21,181	6
7	M.B.FINANCIAL BANK		X	BUSINESS LOAN	DEMAND	8/02	90,000	70,680	9/3/04	5.5000	5,998	7
8	A. I. CREDIT CORPORATION		X	INSURANCE FINANCIAL							5,762	8
9	TOTAL Facility Related						\$ 540,000	\$ 504,226			\$ 33,059	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 540,000	\$ 504,226			\$ 33,059	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$	71,461	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	74,385	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	2,924	3	
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	75,129	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	78,053	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1998		8		
	1999		9		
	2000	67,107	10		
	2001	71,461	11		
	2002	74,385	12		
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL					
THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.					
	FOR OHF USE ONLY				
13	FROM R. E. TAX STATEMENT FOR 2002	\$		13	
14	PLUS APPEAL COST FROM LINE 5	\$		14	
15	LESS REFUND FROM LINE 6	\$		15	
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16	

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

PARKVIEW TERRACE

COUNTY

ROCK ISLAND

FACILITY IDPH LICENSE NUMBER

0045294

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	07-514-20-00	NURSING HOME	\$ 74,384.88	\$ 74,384.88
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 74,384.88	\$ 74,384.88

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,040 **B. General Construction Type:** Exterior BRICK Frame Number of Stories

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ **2. Number of Years Over Which it is Being Amortized:** _____

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	A-WING PAINTING & REFURBISHING OF RESIDENT ROOMS			2002	6,000	2,000	5	1,200	(800)	2,400	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,000	\$ 2,000		\$ 1,200	\$ (800)	\$ 2,400	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 3,526	\$ 705	\$ 352	\$ (353)	10	\$ 528	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	MGMT CO ALLOCATION		449	449				74
75	TOTALS	\$ 3,526	\$ 1,154	\$ 801	\$ (353)		\$ 528	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	9,526
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	3,154
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	2,001
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(1,153)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	2,928

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: EAST MOLINE GARDEN PLAZA
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		120	02/01/01	\$ 279,505	10		3
4	Additions							4
5								5
6								6
7	TOTAL		120		\$ 279,505			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☒ X
- YES
- ☐
- NO
- Terms:
-
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 17,264
- Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	1998 FORD WINDSTAR	\$ 350.00	\$ 4,775	17
18	ADMINISTRATIVE	2001 LEXUS	643.00	8,455	18
19					19
20					20
21	TOTAL		\$ 993.00	\$ 13,230	21

10. Effective dates of current rental agreement:

Beginning 02-01-2001

Ending 01-31-2011

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2004	\$ 279,000
13.	12/31/2005	\$ 345,000
14.	12/31/2006	\$ 351,900

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 32,656	\$		\$ 32,656	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,648			2,648	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			47,128			47,128	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				16,448		16,448	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RENTALS	39-2					310		310	13
	Other (specify): MEDICAL SUPPLIES	39-2					420		420	
14	TOTAL			\$		\$ 82,432	\$ 17,178		\$ 99,610	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 75,590	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	512,412		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	80,857		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	44,711		8
9	Other(specify): Real Estate Tax Escrow	59,439		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 773,009	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	36,000		15
16	Equipment, at Historical Cost	3,526		16
17	Accumulated Depreciation (book methods)	(3,052)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 36,474	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 809,483	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 474,928	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,858		28
29	Short-Term Notes Payable	717,316		29
30	Accrued Salaries Payable	39,283		30
31	Accrued Taxes Payable (excluding real estate taxes)	59,906		31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,129		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,400,420	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,400,420	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (590,937)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 809,483	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (514,473)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	8,969	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (505,504)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(85,433)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (85,433)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (590,937)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,794,123	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,794,123	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	9,348	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 9,348	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,803,471	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	536,049	31
32	Health Care	1,060,771	32
33	General Administration	703,076	33
	B. Capital Expense		
34	Ownership	423,698	34
	C. Ancillary Expense		
35	Special Cost Centers	99,610	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,888,904	40
41	Income before Income Taxes (line 30 minus line 40)**	(85,433)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (85,433)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,626	2,763	\$ 72,885	\$ 26.38	1
2	Assistant Director of Nursing	1,088	1,120	23,880	21.32	2
3	Registered Nurses	4,555	4,933	87,396	17.72	3
4	Licensed Practical Nurses	17,207	18,260	275,377	15.08	4
5	Nurse Aides & Orderlies	40,910	42,749	371,482	8.69	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,383	2,592	24,242	9.35	8
9	Activity Director					9
10	Activity Assistants	4,016	4,481	41,122	9.18	10
11	Social Service Workers	3,340	3,788	41,347	10.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,947	16,531	121,695	7.36	15
16	Dishwashers					16
17	Maintenance Workers	2,372	2,626	42,566	16.21	17
18	Housekeepers	10,386	11,491	76,734	6.68	18
19	Laundry	3,731	4,199	30,544	7.27	19
20	Administrator	4,236	4,386	90,856	20.72	20
21	Assistant Administrator	819	823	24,700	30.01	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,045	5,316	61,022	11.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	674	674	8,339	12.37	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Attached</u>	4,045	4,231	72,438	17.12	33
34	TOTAL (lines 1 - 33)	122,380	130,963	\$ 1,466,625 *	\$ 11.20	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 8,141	1-3	35
36	Medical Director	O	12,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	4,385	10-3	38
39	Pharmacist Consultant	H	450	10-3	39
40	Physical Therapy Consultant	L	5,703	10a-3	40
41	Occupational Therapy Consultant	Y	3,729	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	385	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	E			46
47	<u>PSYCHO-SOCIAL CONSULTANT</u>	S	1,385	10-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 36,178		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses		N/A	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
ROBERT TALBOT	ADMIN	0	\$ 90,856	Workers' Compensation Insurance		\$ 73,860	IDPH License Fee	\$ 200
DAVID SERRANO	ADMIN	0	24,700	Unemployment Compensation Insurance		11,963	Advertising: Employee Recruitment	19,457
				FICA Taxes		116,021	Health Care Worker Background Check	1,188
				Employee Health Insurance		28,996	(Indicate # of checks performed 85)	
				Employee Meals		#REF!	MARKETING/ADV/PROMO	2,160
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	320
				EMPLOYEE BENEFITS - OTHER		9,661	LICENSES & PERMITS	2,628
				EMPLOYEE PHYSICAL EXAMS		0	DUES & SUBSCRIPTIONS	7,025
				PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOCATION	479
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 115,556	CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(320)
(List each licensed administrator separately.)				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(0)
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(2,160)
Description			Amount					
			\$ 0				Yellow page advertising	(0)
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ #REF!	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								18,027
							MGMT CO ALLOCATION	9,059
							Seminar Expense	
								0
SEE ATTACHED SCHEDULE			45,364				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 45,364	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)							TOTAL	\$ 27,086

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$6414
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
PARKVIEW HEALTHCARE CENTER INC. #0039297 04/27/01
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees